The assessment of client satisfaction with mental health services: A review for the practitioner

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Abstract
In the last several years, mental health providers have realized the importance of assessing the consumer's (client or patient) satisfaction with their services (Loff, Trigg, & Cassels, 1987). This is in part due to a legislative change regarding Community Mental Health Centers. The 1975 amendments to the Community Mental Health Center (CMHC) Act require centers to assess and evaluate (among other topics) the "acceptability of services" (Windle & Paschall, 1981). While governmental programs have been mandated to become more accountable, even private agencies have felt some pressure to show whether clients are satisfied with the counseling provided (Royse, 1985). Today, consumer satisfaction surveys are a standard part of the practice of many mental health facilities (Lebow, 1982a). Lebow has stated the convergence of several factors including the increasingly frequent use of mental health program evaluation, the movement to a more consumer-oriented society, increased financing of treatment services by government and third-party payment, the broadened make-up of the clientele, and the ease of administration of measures of consumer satisfaction has resulted in this development.
The Assessment of Client Satisfaction With Mental Health Services:

A Review For the Practitioner

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In the last several years, mental health providers have realized the importance of assessing the consumer's (client or patient) satisfaction with their services (Loff, Trigg, & Cassels, 1987). This is in part due to a legislative change regarding Community Mental Health Centers. The 1975 amendments to the Community Mental Health Center (CMHC) Act require centers to assess and evaluate (among other topics) the "acceptability of services" (Windle & Paschall, 1981). While governmental programs have been mandated to become more accountable, even private agencies have felt some pressure to show whether clients are satisfied with the counseling provided (Royse, 1985). Today, consumer satisfaction surveys are a standard part of the practice of many mental health facilities (Lebow, 1982a). Lebow has stated the convergence of several factors including the increasingly frequent use of mental health program evaluation, the movement to a more consumer-oriented society, increased financing of treatment services by government and third-party payment, the broadened make-up of the clientele, and the ease of administration of measures of consumer satisfaction has resulted in this development.

In the last few years, there has been a rapid expansion in the assessment of consumer satisfaction (Lebow, 1987). Despite this rapid expansion, a coherent literature on the
subject has yet to develop and the results of research completed has yet to be comprehensively summarized (Lebow, 1982a; 1984). Lebow (1987) indicated that the emergence of some well executed studies suggested a promising future for the study of consumer satisfaction with mental health services. However, the field can be confusing and confounding for the general practitioner. My original interest in this field was as a practitioner. I had the hope to find a specific instrument to use in evaluating my clients' satisfaction with services rendered.

My search was at first frustrating as there are few articles written with the clinician in mind and there is discrepancy within the research available. There were identified numerous methodological problems and practical difficulties which have vitiated the value of much of the research to date (Lebow, 1983a). There are also few articles for the practitioner in terms of establishing guidelines for using a formal instrument to measure client satisfaction. It is recognized this is in part due to the fact evaluators have not agreed on a clear, standardized method for measuring client satisfaction (Berger, 1983). Furthermore, specific problems identified with the current assessment techniques available have made it difficult to develop guidelines to
assist clinicians in interpreting results that would be meaningful (Lebow, 1984).

Despite the persistent conceptual ambiguity and problems in the measurement of client satisfaction, mental health professionals have shown a sustained and growing interest in client satisfaction (Lehman & Zastowny, 1983). Berger (1983) pointed out that surveys of client satisfaction provide data about the outcome of therapy untapped by other outcome measures. To summarize, measures of client satisfaction can have an important place in the evaluation of mental health services; however, the results of consumer surveys must be carefully interpreted (Lebow, 1987).

It is the intent of this paper to provide the general practitioner an overview regarding the evaluation of client satisfaction including conceptual, methodological and pragmatic issues, to provide useful comparative information to counselors.

Defining Consumer Satisfaction

The term consumer satisfaction has been used to describe a broad range of research and investigators have defined and operationalized consumer satisfaction differently (Lebow, 1984). Satisfaction can be defined in a narrow sense (the extent to which treatment fulfills the wants, wishes and desires for treatment of the client) as well as in a broader
sense (which includes all the correlations of the narrow definition). This paper will focus on satisfaction operationalized within the narrow definition and address direct inquiries into aspects of satisfaction. For general purposes as a practitioner, satisfaction can be defined as a set of positive and/or negative feelings resulting from receiving mental health services (Berger, 1983).

Why Assess Consumer Satisfaction?

Schwab and Stone (1983) summarized the three primary reasons those working in the field cited as reasons for assessing client satisfaction: (a) the need to provide program evaluation representing the client's not just the provider's view, (b) legislative requirements to include clients in the evaluative process, and (c) supplier domination of publicly funded services, a situation which leaves the disadvantaged with little recourse if unsatisfied.

The ability to demonstrate client satisfaction has also served the important function of helping many agencies acquire community support and continued funding (Windle & Paschall, 1981). Likewise, given the diverse nature of most mental health center populations, satisfaction evaluation can increase provider sensitivity to the unique reactions to treatment of various subgroups of the overall client population (Dickerson, 1985).
In summary, satisfaction data offers a "quality of care" index which can be included in any comprehensive assessment of service effectiveness. It can act as a check upon the existing functioning of the service delivery system. The assessment of client satisfaction can assist in monitoring all services, to examine specific services, to compare treatments within service and to assure quality within services.

Current Status of Research

In addition to a brief overview of the trends and problems as noted in the literature available, the reader is referred to papers by Lebow (1982a; 1983a; 1983b) for a more thorough review of research.

Unfortunately, well-controlled studies are rare in the literature (Lehman & Zastowny, 1983). Researchers have struggled to construct a psychometrically adequate scales with demonstrated validity (Attkisson & Zwick, 1982). The results of the research efforts have yet to be comprehensively summarized (Lebow, 1983b).

In recent years, attempts have been made to rectify these problems. One journal (Evaluation and Program Planning) devoted an entire volume in 1983 to provide extensive discussion of the measurement and meaning of client satisfaction. Also the work of the group at the University
of California, San Francisco (Attkisson & Zwick, 1982; Larsen et al., 1979; Levois et al., 1981) as well as others have begun to provide replicable methods (Lebow, 1987). There has also been efforts (e.g., Lehman & Zastowny, 1983; Tanner & Stacy, 1985) to establish norms for satisfaction assessment instruments in order to facilitate the understanding and interpretation of the scores.

Results of the Research

It is well established that the majority of clients evaluated express positive attitudes about the services received (Lehman & Zastowny, 1983). The vast majority of published studies indicate that clients almost invariably report high levels of satisfaction (Royse, 1985). This is in spite of surveys being conducted in diverse settings (e.g., outpatient counseling and inpatient hospitalization), in dissimilar settings, using various counseling approaches and assessment methods.

Lebow (1983b) after reviewing 34 reported studies of outpatient services offered the following summarization: three studies revealed satisfaction rates between 91% and 100%, thirteen between 81% and 90%, nine between 71% and 80%, seven between 61% and 70%, and two between 41% and 60% (p. 216). He also noted a similar pattern pertaining to evaluations of inpatient services. He questioned how well
these reported levels approximate actual satisfaction given the methodological problems in the research that might result in distortion in the level of satisfaction. The results should be regarded as subject to some degree of error. The estimation of the exact level of satisfaction will require better controlled research. The satisfaction reported in consumer surveys appears at least comparable to that expressed with other human services (Gutek, 1978).

There are few consistent trends evident which links the degree of satisfaction to particular client or treatment characteristics. It is Lebow's (1983a) contention that the client demographic characteristics which have emerged from the research available are particularly poor predictors of satisfaction. He indicated that the following factors have shown some promise as predictors: client level of aspiration, client worldview, fulfillment of client expectations and completion of treatment. It is noted by Attkisson and his associates (Attkisson & Zwick, 1982; Nguyen et al., 1983) that there is a relationship of satisfaction to therapy outcome. Client rated therapy gain is said to be correlated with client satisfaction, but apparently less so as the measure becomes more specific.

Lehman and Zastowny (1983) completed a meta-analysis of the literature to establish norms with various types of mental
health programs. (A meta-analysis refers to using various analytic procedures for reviewing the literature by combining the results of independent studies.) Programs were categorized according to three dimensions: inpatient vs. outpatient vs. residential care; chronic vs. non-chronic; and conventional vs. innovative treatment. A total of 59 programs in 52 studies were analyzed. The analysis revealed that chronic patients express less satisfaction with their treatment compared to non-chronic patients. Innovative programs are viewed more positively than conventional ones. No differences were found in rates of patient satisfaction between inpatient and outpatient programs. The authors indicated that acceptably reliable norms were established for comparative purposes by program evaluators. A cumulative, national data base on patient satisfaction was recommended to further refine the norms.

Research Problems

In two comprehensive reviews of client satisfaction literature (Lebow, 1982a; 1983a), he elaborated the problems associated with the research. The methodological problems arise in the construction of measures, in the procedures followed to collect data, in the biasing of responses, in the lack of variability in response, and in data analysis and reporting.
The measures used to assess satisfaction have had a number of limitations: inclusion of items not assessing satisfaction, ambiguity and oversimplification of response alternatives, lack of precise meaning of terminology, failure to consider meanings of neutral responses or to sufficiently probe. In general, many problems with the measures stem from the tendency of investigators to invent their own questionnaires (Nguyen, et al., 1983). One group of authors (Sorenson, Kantor, Margoles, & Galano, 1979) noted in their survey that 89 different measures were used by various centers in their efforts to assess client satisfaction. Due to this tendency of researchers to develop their own instruments, there are few widely used ones (Lebow, 1984; Berger, 1983). This problem has made it difficult to compare data across studies or to refine existing scales (Berger, 1983). As a result of using unstandardized instruments, it is often difficult to place much confidence in the data or to make meaningful comparisons with other studies (Royse, 1985).

Simple bias has posed a serious threat to the validity of client satisfaction assessment (Dickerson, 1985). In many studies, particularly those involving post treatment surveys, a sizeable portion of the sample either fail to respond to the requests of the investigator or are lost to contact. Lebow (1983b) noted that of 31 studies reviewed,
ten reported client response rates of only 20% to 40%, eight between 41% and 60%, seven between 61% and 80%, and only six between 81% and 100%. Other research suggest that respondents differ in important ways from those who fail to respond to satisfaction queries (Dickerson, 1985).

Another problem is the failure to use comparable measures across research efforts (Lebow, 1982a). As noted the majority of client satisfaction studies in the literature report high levels of satisfaction. The level of satisfaction in absolute terms and in isolation from other data, is meaningless (Nguyen, et al., 1983). A related problem has been the failure to identify baseline levels of satisfaction to which programs can be compared. Different baselines will be needed for particular combinations of types of clients, therapist, treatment and methods of assessing satisfaction (Lebow, 1982a).

As there has been so little methodologically and theoretically sophisticated research assessing consumer satisfaction with mental health treatment, the area is ripe for further research (Lebow, 1983b). Given the different concerns about satisfaction data and research counselors might assume there is no value in conducting client satisfaction surveys. This author, like others in the field (e.g., Royse, 1985; Lebow, 1987), would not defend that solution, but would argue that in spite of all their
can readily be added to the scales without altering their integrity (Lebow, 1987).

**Measures**

Attkisson's Client Satisfaction Questionnaire (CSQ) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979; LeVois, Nguyen & Attkisson, 1981; Pascoe & Attkisson, 1983) is recommended as a survey instrument as it has been used in far more studies and facilities than any other instrument.

The CSQ has three variants: an eight item scale of general items and two 18 item versions (CSQ-18) that add inquiries about more specific aspects of care. The CSQ-8 should prove sufficient for global inquiries about patient satisfaction, while the CSQ-18 is preferable where there is greater concern about specific aspects of acceptability (e.g., assessibility, cost). (Lebow, 1987, pp. 192-193)

It is reported that three items from the CSQ-8 also appear to function well as a small global measure of satisfaction (Nguyen, et al., 1983).

Other suggested questionnaires for outpatient treatment include those developed by Flynn, Balch, Lewis, and Katz (1981); Love, Caid, and Davis (1979); and Slater, Linn, and Harris (1982). Distefano, Pryer, and Garrison (1980) offered
includes a series of items focused on those aspects of care of unique interest to those facilities (Lebow, 1987). It is beyond the scope of this paper to address the specific psychometric properties of these instruments. The interested reader is recommended to consult the specific authors for more information regarding these questionnaires.

Procedures for Data Collection

There remains a number of specific choices in procedure regarding the collection of consumer satisfaction data. Some of these choices will be determined on an administrative level because they involve cost and time usage. Other choices will be determined by the results desired. For example, personal interview tend to yield high response rates but this approach is also the most expensive. Mail surveys are less expensive but tend to have the lowest response rates (Royse, 1985).

Once choice involves who will be surveyed and basically there are three options: to survey 1) all the recipients of treatment, 2) a representative sample of clients, and 3) a focused sub-sample (e.g., participants in a parent training program). It is reported that most efforts have opted for surveying all recipients even though sampling offers the possibility of greater efficiency of effort (Lebow, 1987).
Related to who will be assessed is how the data will be collected. Recognizing that even with a standardized instrument the data can be collected through a variety of ways including oral interview conducted at the treatment facility (or home), through written questionnaires presented at the facility (or home), through telephone interviews, or through mailed questionnaires. Each mode of collection has its own strengths and weaknesses.

Oral presentation results in more positive results than written methods, an effect probably due to the increased reactivity associated with oral presentations (Levois, et al., 1981). Lebow (1982b) stated that with responses collected at the treatment facility, either by interview or questionnaire high rates of responding and small differences in responding across groups are likely. Mail distribution is the least reactive and least expensive, but results in greatest subject loss and differential attrition. It was Lebow's opinion that since none of the location/mode combinations emerges as being vastly superior, practical considerations should determine the combination chosen. He did recommend that where possible, multiple methods should be utilized to increase response rates. Second attempts to contact clients are emphasized with whatever method is chosen.
There are also needs to be given consideration about who presents the survey. While involving the provider of the service increases the level of compliance, it also effects the results. In an attempt to minimize bias it is best to employ someone other than the provider to collect the data. It is also important to clarify the purpose of the survey, to emphasize a general interest in the responses of the clients, and to point out the need for both positive and negative feedback. It was not recommended that clients be granted anonymity because the loss of information far outweighs the advantages that accrue from anonymity (Lebow, 1987). Instead, it is recommended that the uses of data be qualified (that is, point out the data will not be shared directly with the care provider and deidentified in any use).

Another choice affecting the procedure is the timing of the evaluation. Consumer satisfaction data has been gathered at several points in the course of treatment including during treatment, at the close of treatment at a fixed point after treatment (e.g., six months) or at variable points after treatment. The point in time chosen may affect the evaluation and what is being evaluated. Edwards et al. (1978) demonstrated differences between satisfaction at the second session, termination and follow-up.
Specifically, evaluations at an early point in treatment can be expected to focus on the engagement process. While these measures are poor predictors of later satisfaction, they are important in determining early acceptability and continuation in treatment. Any point in time is an acceptable alternative, although it is felt that in the majority of the instances client reaction at the close of treatment will be most relevant (Lebow, 1987). It is important to not overlook those clients who dropped out of treatment early (Royse, 1985).

Two specific groups warrant special consideration: the child client population and the severely dysfunctional clients who suffer from severely impaired judgments (e.g., the extremely retarded or psychotic). Children's perceptions of, and satisfaction with mental health services have received little attention (Loff, et al., 1987). Schwab and Stone (1983) pointed out that we know very little about how young clients view their treatment and this in part reflects the paucity of work in the field. They also pointed out that conceptual issues make the task a difficult one, and few methodologies have addressed the unique aspects of treatment satisfaction from the viewpoint of the developing child. The most complicated factor is the role of cognitive developmental change, which influences how children view the causes of
their problems and consequently their perceptions of the treatment provided.

It is recommended that the child client's viewpoint be assessed, but due to the above mentioned concerns, there needs to be special consideration given when analyzing the results. Assessment should include other family members not in treatment. When family treatment occurs, each family member should be contacted as the assumption that one family member speaks for the family is often a shaky one (Lebow, 1987).

While a representative sample of all clients is desirable, caution is suggested to extend this principle to include those severely dysfunctional clients. While a conservative stance is felt best, removing only those with extreme dysfunction, limiting the sample is necessary in settings where many dysfunctional clients are present (e.g., locked inpatient wards), if the data is to have meaning (Lebow, 1983a). Whichever choice is made, criteria for exclusion and number of clients excluded must be articulated. Lebow emphasized that in many instances such information was not reported.

Finally, by supplementing the standard scale with at least one "open-ended" question, a wealth of additional information can be supplied (Royse, 1985). An example of
such a question could be "What would you like to change about services?" Adding such items increases the utility of the information as well as the feeling on the part of the respondent that information has been communicated (Lebow, 1987).

Conclusion

In summary, client satisfaction represents an important dimension of evaluation in mental health treatment. By providing both qualitative and quantitative data, information for statistical comparison is generated as well as comments regarding practical concerns of clients. Client satisfaction surveys are useful for getting at one facet of quality assurance and for getting feedback from the consumer's perspective.

Although these measures are flawed, they can be quite useful when considered with the limitations in mind. It is important that the practitioner use those methods that have demonstrated validity. The main concern is to improve the accuracy of client satisfaction measurement and interpretation so that this form of evaluation yields the type of useful information that will help improve the delivery of mental health services.
References


